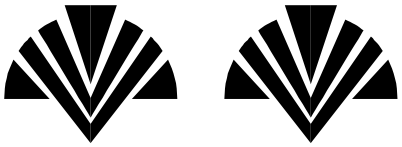
THE ENHANCED SCHOOL HEALTH SERVICES PROGRAM DATA REPORT



Executive Summary

1996-97 School Year

Massachusetts Department of Public Health
Bureau of Family and Community Health, Office of Statistics and Evaluation

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Acknowledgments

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Introduction

The health needs of students in Massachusetts, as in the rest of the country, have become increasingly complicated in recent years.

> *Children attending schools in the Commonwealth today are faced not only with the usual and common infectious diseases, they face the threat of other major health problems not always well understood by teachers, parents and the community. Special needs children integrated into the classrooms of every town have significant health and nursing needs... The administration of medication and the monitoring of their effects, coupled with the needs of children from dysfunctional families, further complicate the picture of school health. (The Report of the Special Commission Established to Make an Investigation and Study Relative to the Practice of Nursing in the Commonwealth*, 1992*)*

The Enhanced School Health Services Program

In 1993, the Enhanced School Health Services Program (ESHSP) was created to strengthen the quality of health services provision in Massachusetts public schools. The program design incorporated exemplary components of existing school health services programs throughout the state. With funding from the Massachusetts Health Protection Fund, the ESHSP supported **36** school districts in the Commonwealth (**10.4%** of the state total) for three years to:

- strengthen the infrastructure of school health services in the areas of personnel and policy development, programming, and interdisciplinary collaboration;
- incorporate health education programs, including tobacco prevention and cessation activities, into the existing school health program; and
- develop linkages between school health services programs and community health care providers.

School systems were selected for participation through a competitive bid process based on a Request for Proposals (RFP) developed by the Massachusetts Department of Public Health (MDPH). The program has been administered by the School Health Unit within the MDPH Bureau of Family and Community Health, Division of Prevention.

Data Collection Methods

Over the course of the project, data were collected from the 36 ESHSP school districts (see **Appendix A**) whose contractual obligations required them to submit **program profile reports** *twice a year* and **activities reports** *once a month* to MDPH. The **program profile report** solicited information about student demographics and program infrastructure; the **monthly activities report** focused on questions regarding health services activity. Not surprisingly, data from the program profile report changed little over time, while data from the monthly activities report fluctuated from month to month.

This summary program activity report was generated from a subset of data collected during the **1996-97** school year. Information from the monthly activities report, aggregated for the time period **January 1 - April 30, 1997** (four months),* was received from **32** school systems (**88.9%** of program total) serving a total of **183,525** enrolled students (**19.6%** of state total). The median number of students per district was **3,511**, with a range of **114 to 24,422** enrolled students.

Program profile report data, aggregated for the **1996-97** school year, were collected from a subset of **34** sites (**94.4%** of program total) serving a total of **246,894** enrolled students (**26.4%** of state total). In this case, the median number of students per district was **3,511**, with a range of **114 to 63,239** students per district across school systems. Urban, suburban, and rural districts were represented in these samples, as were regional school systems, vocational school systems, and special education collaboratives. Rates were calculated utilizing October 1996 student enrollment figures provided by the Massachusetts Department of Education (see **Appendix A**). Both sets of data were cleaned for data-entry errors and outlying values. Where possible, **rates per month** were used as the standard unit of analysis.

Data Limitations

This report focuses exclusively on the delivery of school health services by *nursing* staff. In addition, because project sites were not selected to serve as a representative sample of the Commonwealth, this summary is descriptive in nature and is not intended to be used to make generalized statements about health services in all Massachusetts public schools. The descriptive data presented here also does not capture the dynamic and multi-faceted nature of health services delivery in a school system, which would require in-depth qualitative analysis of the program sites. Furthermore, most project sites were not computerized and relied on hand-tallying of data by individual nurses in their districts. Hence, it was impossible to control for factors including data-entry errors at the district level, consistent misinterpretation of survey questions, and numerical "guesstimates" provided by participants. Finally, interpretation of this data is limited due to the lack of specific knowledge about collateral factors including school district structure and local issues. Technical notes regarding statistical measures used in this report can be found on page 11.

Participating districts were required to implement, in a short period of time, both program innovations that entailed major organizational change and, in most cases, the development of an internal data collection system (see **Appendix B**). Therefore, this report represents a preliminary attempt to measure the health services activity in these participating school systems. As sites continue to improve their data collection methods during the next funding cycle, it is expected that data validity and reliability will continue to improve as well.

Data Summary

School Nurse Staffing Patterns

Among **32** reporting districts in the Enhanced School Health Services Program, the equivalent of **278.1** full-time school nurses served a total of **183,525** enrolled students during the 1996-97 school year.

** These months were chosen because the greatest number of districts submitted data for this time period.*

Each nurse was responsible for a median number of **598** students, a significantly better ratio than that recommended by the American Nurses Association (ANA) for regular education populations: **1 to 750**.[1] Across the 32 districts, nurse to student ratios ranged from **1: 114 to 1: 1,480**; seven of those districts (**21.9%**) had nurse to student ratios that fell below the ANA guidelines.

Of the **278.1** school nurse full-time equivalents (FTEs):

- **38.9 (14.0%)** were funded by the MDPH Enhanced School Health Services Program;
- **239.2 (86.0%)** were funded through local school budgets and other sources.

School Health Services Activity

The primary goals of the Enhanced School Health Services Program are to reinforce the infrastructures of existing school health services programs and to improve the delivery of health services to students. Toward that end, participating sites were required to assess over time the type and scope of school nursing activity in their districts. These activities were divided into seven categories of data which are presented below: **1) health encounters, 2) injury reports, early dismissals, and referrals for emergency health services, 3) medication management, 4) health screenings, 5) medical procedures, 6) linkages, and 7) nursing case management**. *Unless otherwise specified, the following data provide a **four-month overview** of the health services activity in these districts during the 1996-97 school year.*

Health Encounters

Districts tracked on a monthly basis the total number of school-based student health encounters. An "encounter" was defined as *any contact with a student during which the school nurse provided counseling (ad hoc), treatment, or aid of any kind*. Casual conversations, mandatory screenings, and scheduled counseling sessions were not included in this count; population-based activities such as mandatory screenings were addressed in the semi-annual program profile report.

Between January 1 and April 30, 1997, 32 school districts reported a total of **693,259** student health encounters and a median number per district of **3,612** encounters *per month* (range: **23 to 23,545** encounters per district).

Of the **693,259** student health encounters:

- **646,985** encounters (**93.3%** of total) occurred in a school health room (i.e., nurse's office);
- **46,274** encounters (**6.7%** of total) occurred elsewhere in the school.

Over the four-month period, the median rate of health encounters *per student* was **1.0** per month; the median rate of student health encounters *per full-time school nurse* was **588.1** per month.

Health service encounters with school staff (i.e., teachers, administrators) regarding their *own* health issues were also monitored by school systems. During the same four-month period, 278.1 full-time school nurses managed a total of **18,182** staff health encounters. The median number of staff health encounters per district

[1] *Standards of School Nursing Practice*, Kansas City: MO, 1983.

was **94** per month, with a range of **3 to 1,095** encounters per district across 32 school systems. Each full-time school nurse handled a median rate of **12.1** staff health encounters per month during this time.

Injury Reports, Early Dismissals, and Referrals for Emergency Health Services

An important function of school nursing practice is to provide on-site health services to students who are sick, injured, or experiencing a serious health emergency. Sites tallied each month the number of student injury reports, early dismissals due to illness, and referrals for emergency health services in their districts. These events represent a small subset of the total number of student health encounters in a school system. For the first four months of 1997, 32 districts reported:

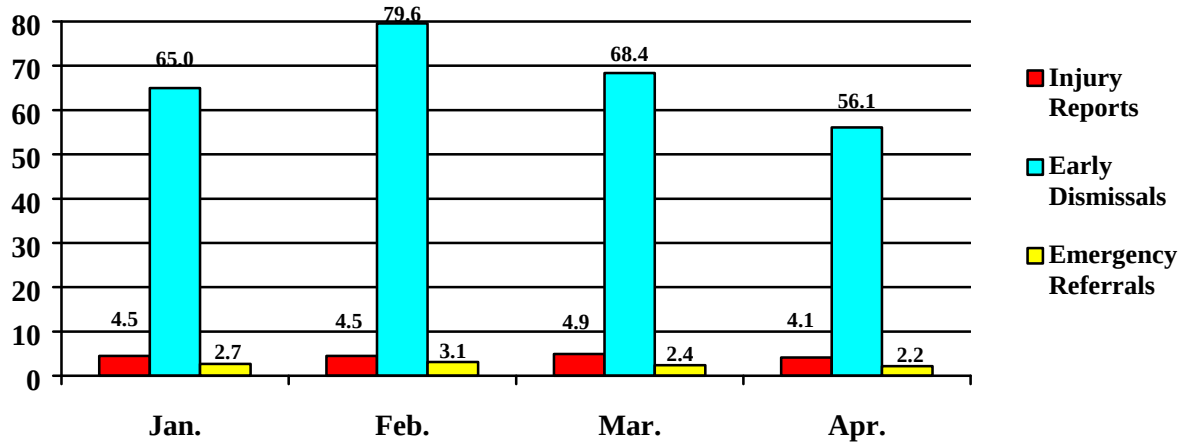
- a total of **4,221** *injury reports* and a median per district of **16** reports per month (range: **4 to 151** reports per district);
- a total of **52,901** *early dismissals due to illness* and a median per district of **225** dismissals per month (range: **4 to 1,896** dismissals per district);
- a total of **1,869** *referrals for emergency health services* and a median per district of **6** referrals per month (range: **0 to 79** referrals per district).

The following graph compares, *for every 1,000 student health encounters*, the median rates per month of student injury reports, early dismissals due to illness, and referrals for emergency health services in each district for the time period January 1 - April 30, 1997:

Student Injury Reports, Early Dismissals, and Referrals for Emergency Health Services:

Median Rates Per Month, Per 1,000 Student Health Encounters

January 1 - April 30, 1997 (n=32)



Medication Management

In 1993, the Massachusetts Department of Public Health promulgated regulations governing the administration of medications in public and private schools. The purpose of these regulations (105 CMR 210.000) is to provide minimum safety standards for the administration of prescription medications to students in the Commonwealth.

The school nurse's role in managing the medication administration program for the district is broad in scope. In addition to developing district-wide medication policies in collaboration with the school committee, school administration, and school physician, the school nurse:

- administers medications to students;
- delegates the administration of selected medications to appropriate school staff (if the district is registered with the MDPH to do so);
- ensures the proper training of these designated staff; and
- establishes a formal record-keeping system for the district's medication administration program.

School systems participating in the Enhanced School Health Services Program tracked monthly the numbers of students on a variety of prescription medications. The total number of prescriptions per month was derived by calculating for each site the monthly average number of prescriptions for each medication and then summing these averages across the sites. Between January 1 and April 30, 1997, 32 sites reported a total of **10,592** students per month on *short-term* and *long-term* prescription medications, a median of **328** students per district (range: **2 to 739** students per district). The following four types of medications accounted for **79.2%** of all student prescriptions:

- a total of **4,253** students per month on *asthma* medication, a median of **95** students per district (range: **8 to 379** students per district);

- a total of **648** students per month on *Ana Kit* or *Epinephrine*, a median of **16** students per district (range: **2 to 71** students per district);

- a total of **3,307** students per month on *psychotropic* medications, a median of **70** students per district (range: **14 to 394** students per district);

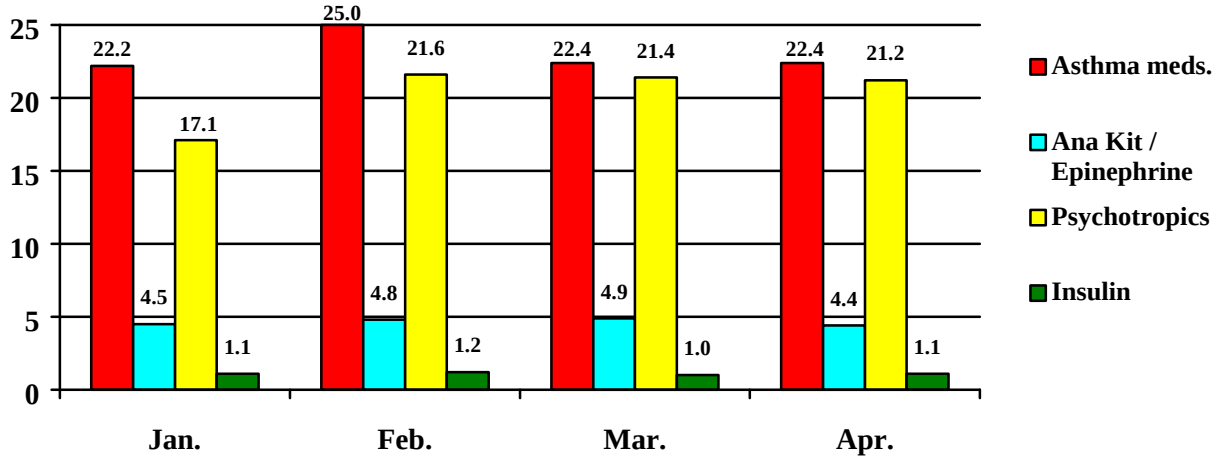
- a total of **177** students per month on *Insulin*, a median of **5** students per district (range: **0 to 18** students per district).

The following graph compares, across 32 school systems, median prescription rates per month among four types of medications. These numbers reflect the median rates of students per district *known by school nurses* to be on prescription medication each month, and are, therefore, most likely *underestimates*.

Students on Selected Prescription Medications:

Median Rates Per Month, Per 1,000 Students

January 1 - April 30, 1997 (n=32)



Health Screenings

Public schools in Massachusetts are required by law to conduct postural, hearing, and vision screening on all students.* School nurses are responsible for ensuring that these screenings are completed and for referring students for follow-up care when needed. During the *entire* 1996-97 school year, school nurses from **34** ESHSP districts conducted the following number of health screenings on students (including *re-screenings*):

- a total of **152,396** *hearing* screenings and a median of **2,610** screenings per district (range: **0 to 27,278** screenings per district);
- a total of **71,860** *postural* screenings and a median of **1,309** screenings per district (range: **0 to 15,176** screenings per district);
- a total of **165,271** *vision* screenings and a median of **3,220** screenings per district (range: **0 to 31,839** screenings per district).

The median and minimum/maximum rates per district of these health screenings (*per 1,000 students*) are as follows:

** The law permits waivers under certain circumstances. Additionally, screenings are done according to grade requirements.*

Student Health Screenings: Median and Minimum/Maximum Rates Per 1,000 Students 1996-97 School Year Totals (n=34)

Type of Screening	Median Rate/ 1,000 Students	Min.-Max. Rates/ 1,000 Studs.
Hearing	675.4	0 - 1,000.0
Postural	353.1	0 - 552.9
Vision	695.4	0 - 1,000.0

Some school systems have opted to conduct voluntary health screenings based on the particular health needs of their students. Dental screenings are among this list. During the first four months of 1997, **16** ESHSP districts conducted a total of **8,163** student *dental* screenings. In these 16 districts, the median number of dental screenings per district was **95** per month, with a range of **2 to 1,376** screenings per district across school systems.

Medical Procedures

The enrollment of children assisted by medical technology in the public school system has increased dramatically in recent years. This phenomenon presents multiple challenges for school administrators, parents and guardians, school health services personnel, teachers, and, of course, students. ESHSP school districts collected data on students assisted by medical technology. *The calculations below are based only on those districts that conducted the specified procedures*. For the time period January 1 - April 30, 1997, school districts reported the following:

- a total of **2,478** *urethral catheterization* procedures performed on students (*n=18 districts*) and a median per district of **31** procedures per month (range: **10 to 69** procedures per district);

- a total of **4,938** *glucometer* procedures performed on students (*n=16 districts*) and a median per district of **44** procedures per month (range: **8 to 317** procedures per district);

- a total of **2,143** *nasogastric/gastric tube care* procedures performed on students (*n=13 districts*) and a median per district of **31** procedures per month (range: **1 to 139** procedures per district);

- a total of **2,394** *nasogastric/gastric tube feeding* procedures performed on students (*n=13 districts*) and a median per district of **51** procedures per month (range: **1 to 148** procedures per district);

- a total of **876** *nebulizer* procedures performed on students (*n=8 districts*) and a median per district of **16** procedures per month (range: **1 to 77** procedures per district);

- a total of **936** *oxygen care* procedures performed on students (*n=8 districts*) and a median per district of **19** procedures per month (range: **0.3 to 107** procedures per district);

- a total of **109** *tracheostomy care* procedures performed on students (*n=6 districts*) and a median per district of **4** procedures per month (range: **0.3 to 9** procedures per district).

The following chart displays, at the district level, the median and minimum/maximum rates per month of these medical procedures *for every 1,000 student health encounters*:

Medical Procedures Performed on Students: Median and Minimum/Maximum Rates Per Month, Per 1,000 Student Health Encounters
January 1 - April 30, 1997

Type of Procedure	Median Rate/ 1,000 Enctrs.	Min.-Max. Rates/ 1,000 Enctrs.
Catheter Care (*n=18*)	5.4	0.6 - 23.0
Glucometer Testing (*n=16*)	13.3	2.4 - 68.3
Nasogastric/Gastric Tube Care (*n=13*)	4.6	0.2 - 15.9
Nasogastric/Gastric Tube Feed'g (*n=13*)	6.7	0.2 - 13.5
Nebulizer Treatment (*n=8*)	3.3	0.3 - 362.9
Oxygen Care (*n=8*)	4.8	0.5 - 133.4
Tracheostomy Care (*n=6*)	0.8	0.04 - 2.1

Linkages

ESHSP school systems identified students without access to primary care and, in consultation with their families, referred them to appropriate health care services. During the first four months of 1997, 31 participating districts reported that they identified and referred:

- a total of **5,252** students to primary care providers, a median per district of **11** students per month (range: **0 to 615** students per district);

- a median rate (*per 1,000 students*) of **2.5** students per month to primary care (range: **0 to 41.9** students per district).

Nursing Case Management

Data from the monthly activities report revealed that, beyond providing direct care to students, school nurses spent a significant portion of their day performing case management duties that included communication with families, other school staff, and community health care providers about student health concerns. Over a four-month period, **277.1** full-time school nurses from **31** districts conducted:

- a total of **84,621** *health counseling and education encounters with parents* and a median per district of **508** encounters per month (range: **2 to 2,917** encounters per district);

- a total of **418** *home visits* and a median per district of **1** home visit per month (range: **0 to 24** home visits per district);

- a total of **34,352** *meetings with other school staff* about student health and a median per district of **141** meetings per month (range: **12 to 1,811** meetings per district);

- a total of **20,562** *phone calls with other school staff* about student health (*n=29*) and a median per district of **46** phone calls per month (range: **0 to 1,566** phone calls per district);

- a total of **10,538** *phone calls with other agencies and health providers* about student health and a median per district of **37** phone calls per month (range: **0 to 375** phone calls per district).

The following chart calculates (*per school nurse FTE*) the median and minimum/maximum rates of case management activities per school district each month across 31 participating districts:

Nursing Case Management Activities: Median and Minimum/Maximum Rates Per Month, Per Nurse FTE
January 1 - April 30, 1997 (n=31)

Type of Activity	Median Rate/ FTE	Min.-Max. Rates/ FTE
Health counseling/education enctrs. with parents	63.5	2.0 - 220.1
Home visits to families	0.1	0 - 3.9
Meetings with staff about student health	21.8	5.0 - 90.6
Phone calls with staff about student health (*n=29*)	8.9	0 - 65.4
Phone calls with agencies/providers re stud. health	6.2	0 - 43.6

For children with special health care needs, nursing case management involves the development of Individual Health Care Plans (IHCPs) designed to maximize their potential for learning. An IHCP, usually developed by the school nurse in conjunction with the student's family, the school physician, other school staff, and relevant community health care providers, is an individualized care plan that stipulates a student's specific medical, nursing, emergency care, and educational needs. IHCPs are reviewed on a regular basis to ensure that students receive the appropriate health care they need during the school day.

During the first four months of 1997, 30 Enhanced sites reported:

- a total of **711** *new* IHCPs and a median per district of **4** new IHCPs per month (range: **0 to 30** IHCPs per district);

- a median rate, per full-time school nurse, of **0.5** *new* IHCPs per month (range: **0 to 2.7** IHCPs per school nurse);

- a total of **2,237** *ongoing* IHCPs per month and a median of **33** ongoing IHCPs per district (range: **0** to **549** IHCPs per district); *

- a median rate, per full-time school nurse, of **6.5** *ongoing* IHCPs per month (range: **0 to 38.2** IHCPs per school nurse).

Health Education and Tobacco Prevention

Finally, school nurses are often called upon to deliver health education in the classroom. Their expertise in this arena may run the gamut from nutrition education to injury prevention to human growth and development. Over a four-month period, 263.8 full-time school nurses in 30 districts delivered:

- a total of **1,522** classroom presentations to students, a median per district of **5** presentations per month (range: **0 to 103** presentations per district);

- a median rate of **0.8** classroom presentations per month per full-time nurse (range: **0 to 9.7** presentations per school nurse).

As part of the Massachusetts Tobacco Control Program, the Enhanced School Health Services Program was designed to incorporate tobacco use prevention and cessation activities into existing school health services programs. Accordingly, Enhanced districts conducted targeted tobacco education activities over the course of the project that included, among other things, at least one survey of student tobacco use. In their most recent efforts, **31** school systems surveyed a total of **28,957** students on their tobacco use, equivalent to **13.4%** of the total student enrollment in these districts. In addition, during the first four months of 1997, a total of **22** tobacco cessation programs were completed in **11** school districts. A median number of **0.3** cessation program per month was completed in each of these school systems, with a range of **0.3 to 1.3** programs across systems.

Conclusion and Recommendations

Data collected by the Enhanced School Health Services Program provide, for the first time, a valuable snapshot of school nursing practice in a diverse cohort of Massachusetts public schools. The data reveal that school nurses perform a wide array of duties -- direct care, health education, administrative case management, and policy/program development and oversight -- on behalf of students whose health needs range from routine to serious and complex.

Future data collection efforts will seek to expand upon current knowledge of health needs in the school setting. Toward that end, sites will be expected to gather information on the *types* of health encounters (student and staff) that occur in school, and their prevalence. Over time, information on potential trends in school health encounter activity may assist school nursing staff in improving their delivery of prevention education and intervention services to the school community. Such data may be further used to examine

** The total was derived by calculating the average number of ongoing IHCPs per month in each district and then summing these averages across 31 school systems.*

possible relationships between the types and/or rates of school health encounters (and health emergencies) and: 1) the ratio of school nurses to students, 2) the number of students with health insurance coverage, 3) the credentials of school nursing staff. Ultimately, the categorization of health encounters and other school health services activities may help school nursing personnel and other interested professionals to determine the cost-benefit of assessing and managing student health needs in school. As the collection of school health data becomes more refined with time, so, too, will the information it yields about student health needs.

Technical Notes

1. Every data element was tested for skewness. Because most elements in this dataset were skewed (< 0 and >1), the *median***,** rather than the *average*, was used to calculate all values. The median represents the number above and below which exactly 50% of the observations fall.

2. Monthly rates *per school district* were derived by calculating the monthly average number of data observations (per indicator) for a district and: a) dividing that number by the total number of enrolled students or student health encounters in the district (depending upon the indicator) and multiplying the resulting number by 1,000, or b) dividing that number by the total number of school nurse full-time equivalents (FTEs) in the district.

3. Median rates *across school districts* were derived by selecting the rate above and below which exactly 50% of the individual district rates fell.

APPENDIX A

Enhanced School Health Services Program Sites: 1996-97

DISTRICT NAME	DISTRICT TYPE	REGION	GRADES	ENROLLMENT
Ashburnham-Westminster	Regional Academic	North Central	K-12	2,447
Assabet Valley	Ed. Collaborative	North/Central	N/A	130
Boston	City	Metro	K-12	63,239
Brockton	City	Southeast	K-12	15,461
Brookline	Town	Metro/Suburban	K-12	6,068
Burlington	Town	West Suburban	K-12	3,488
Cambridge	City	Metro	K-12	7,965
Cape Cod	Regional Voc. Tech.	Southeast Coastal	9-12	540
Central Berkshire	Regional Academic	Greater Western	K-12	2,541
Chelsea	City	Metro	K-12	5,298
Duxbury	Town	Southeast	K-12	2,904
East Longmeadow	Town	Lower Pioneer Valley	K-12	2,614
Everett	City	Metro	K-12	4,993
Fitchburg	City	North Central	K-12	5,431
Framingham	Town	Greater Framingham	K-12	7,758
Hampden-Wilbraham	Regional Academic	Lower Pioneer Valley	K-12	3,534
Hampshire	Ed. Collaborative	Greater Western	K-12	114
Hudson	Town	Greater Framingham	K-12	2,581
Lawrence	City	Merrimack Valley	K-12	11,650
Lexington	Town	West Suburban	K-12	5,442
Lowell	City	Merrimack Valley	K-12	15,759
Lunenburg	Town	North Central	K-12	1,843
Malden	City	Metro	K-12	5,577
Minuteman	Regional Voc. Tech.	West Suburban	9-12, Post Grad.	966
New Bedford	City	Southeast Coastal	K-12	14,661
Newton	City	Metro/Suburban	K-12	10,850
Orange	Town	Greater Western	PreK-6	899
Pioneer Valley	Regional Academic	Greater Western	K-12	1,207
Revere	City	Metro	K-12	5,706
Salem	City	North Shore	K-12	4,902
Saugus	Town	North Shore	K-12	3,287
Springfield	City	Lower Pioneer Valley	K-12	24,422
Taunton	City	Southeast	K-12	7,616
Triton	Regional Academic	Merrimack Valley	K-12	3,398
Uxbridge	Town	South Central	K-12	2,161
Winchester	Town	West Suburban	K-12	3,126

APPENDIX B

Enhanced School Health Services Program
Minimum Deliverables

1. Establishment of a school health services advisory committee.

2. Implementation of an on-site smoking cessation program for students, faculty and families, including a method of assessing the impact of the program (time frame: within six months of the grant award).

3. Achievement of a tobacco-free school by September 1, 1994.

4. Review and revision of current written health policies with development of new policies to cover tobacco, alcohol and other substance use and any other prioritized student health needs.

5. Completion of written job descriptions for all health personnel employed by the school health service program. This includes scope of responsibilities and supervision given and received.

6. Documented attendance of school health service personnel at continuing education programs pertinent to comprehensive school health issues, including attendance at smoking prevention and cessation training programs sponsored by the Department of Public Health and other agencies.

7. Written plan for developing a team approach at the building level to address a variety of student health issues such as early alcohol and/or other substance abuse, poor nutrition, absenteeism, etc. (time frame: within four months of grant award).

8. Plan for identifying those children who lack primary care providers and a beginning plan to link them with community primary care providers as well as other special services such as substance abuse, youth assistance or outpatient programs, and mental health services.

9. Plan for describing the school health services program to community primary care providers and facilitating communication and linkages between the primary care providers and the school health services.

10. Plan for developing and implementing assessment tools for such purposes as: a) student health needs assessment, b) individual student encounters in the health room and other areas, c) a system-wide needs identification, d) program evaluation and/or, e) home visitation.

11. Plan for implementing a nutritional assessment of children seen in the school health room, including growth assessments, identification of potential problems and linkages with resources within the community.

12. Plan for developing a support group(s) specific to identified student needs.

13. Plan for promoting collaborative activities with identified community agencies, including primary care providers or coalitions, which are designed to enhance rather than duplicate efforts to meet certain identified student needs.

14. Plan for developing and implementing the following (time frame: within six months of grant award):
- a written disaster/emergency plan, including a list of the school personnel to be certified in cardio-pulmonary resuscitation and first aid; include plans to make CPR training available to students and expected numbers of students who will receive this training;
- a system of medication administration, consistent with 105 CMR 210.000, which ensures that all students requiring medications during the school day will receive them in a timely and safe manner;
- a written infection control plan, including universal precautions and disposal of hazardous waste, and training of school staff;
- written individual health care plans for students requiring health services in the school (include draft form).

15. Completion of written materials describing the school health program.

16. Plan for data collection on certain health status indicators relevant to the school district's student population and as requested by DPH during the award period. At least one computer meeting the grant specifications should be purchased for the school health services program. The location shall be determined by the school nurse.

17. Plan to implement one additional health-related activity or program, as described in the RFP, designed to meet identified student health service needs in the school district.

18. Written progress reports on the above areas as required by DPH. These shall be shared with the school committee and others, as appropriate.